

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/08/2025
NAME OF PROVIDER OR SUPPLIER Highland Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 904 East 68th Street Kansas City, MO 64131	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>52224</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to provide a privacy cover for a urinary catheter drainage bag for 1 (Resident #63) of 1 resident reviewed for dignity.</p> <p>Findings included:</p> <p>A facility policy titled, Resident Rights Policy, dated 12/2024, indicated, Each resident residing in this community has the right and will be afforded the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the community without interference, coercion, discrimination, or reprisal. The policy also indicated, Resident rights include but are not limited to: Privacy and confidentiality.</p> <p>1. On 02/07/2025 at 2:34 PM, the Administrator stated the facility did not have a policy that addressed protecting the resident's dignity with the use of a privacy cover for a catheter drainage bag.</p> <p>An Admission Record indicated the facility admitted Resident #63 on 09/01/2024. According to the Admission Record, the resident had a medical history that included diagnoses of vascular dementia and obstructive and reflux uropathy.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 12/06/2024, revealed Resident #63 had moderate impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a Staff Assessment of Mental Status (SAMS). The MDS indicated the resident had an indwelling urinary catheter.</p> <p>Resident #63's care plan included a focus area revised 10/03/2024, that indicated the resident had a suprapubic catheter related to obstructive neuropathy. Interventions directed staff to provide catheter care every shift and as needed (initiated 07/10/2023).</p> <p>Resident #63's Order Summary Report, with active orders as of 02/07/2025, contained an order dated 01/09/2025 for the use of a suprapubic urinary catheter every 24 hours as needed for blockage or dislodgement.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations on 02/03/2025 from 11:30 AM until 1:18 PM, revealed Resident #63 was seated in a wheelchair in the dining area. The observation revealed the resident's catheter drainage bag contained approximately 100 cubic centimeters (cc) of yellow urine. The observation revealed the catheter drainage bag with urine was not contained in a privacy cover. The resident's catheter drainage bag with urine was visible to staff, residents, and visitors.</p> <p>During an interview on 02/05/2025 at 3:12 PM, Licensed Practical Nurse (LPN) #20 stated that he/she was the assigned nurse for Resident #63 on Monday (02/03/2025) and he/she forgot to put a privacy cover over the resident's catheter drainage bag. LPN #20 stated that there was no privacy cover over the catheter drainage bag when the resident was sitting out in the common area. LPN #20 stated that the nurse was responsible for ensuring that the catheter drainage bag was covered.</p> <p>The Interim Director of Nursing (IDON) was interviewed on 02/07/2025 at 9:24 AM. The IDON stated that when staff provided catheter care, the catheter drainage bag should be placed in a privacy cover. The IDON stated that the catheter drainage bag should be kept covered for the dignity of the resident and that nobody needed to know that the resident had a catheter. The IDON stated that all staff should monitor to ensure the catheter drainage bag was kept in a privacy bag.</p> <p>During an interview on 02/07/2025 at 9:50 AM, the Administrator stated the charge nurse and unit coordinator should monitor to ensure resident catheter drainage bags were kept in a privacy cover when the resident was in a community area. The Administrator stated the resident's assigned Certified Nurses Aide (CNA) should make sure the privacy cover was in place to provide the resident with dignity.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>52219</p> <p>Based on observation, interview, record review, and facility document review, the facility failed to ensure resident room floors and equipment were cleaned and maintained for 1 (Resident #103) of 4 residents reviewed for environmental concerns. Specifically, the facility failed to ensure tube feeding formula was cleaned off the resident's tube feeding pump, pole, and floor.</p> <p>Findings included:</p> <p>1. An Admission Record revealed the facility originally admitted Resident #103 on 11/20/2023 and readmitted Resident #103 on 01/09/2025. According to the Admission Record, Resident #103 had a medical history that included diagnoses of dysphagia (difficulty swallowing) and gastrostomy status (presence of a surgically created opening in the stomach).</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/18/2024, revealed Resident #103 had a short-term memory problem but was independent with cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS). The MDS indicated Resident #336 utilized a feeding tube while a resident at the facility and received 51 percent (%) or more of their total calories through parenteral or tube feeding.</p> <p>Resident #103's care plan included a focus area, initiated 11/21/2023, that indicated the resident required tube feeding.</p> <p>Resident #103's Order Summary Report contained orders dated 01/09/2025 addressing enteral feedings (by way of feeding tube).</p> <p>An observation on 02/03/2025 at 10:43 AM revealed Resident #103's feeding tube pump had multiple dried splatters in the same color (beige) as their tube feeding formula. The four feet of the metal feeding tube pole also had beige-colored splatters on them, and the floor beneath the feeding tube pole had beige splatters.</p> <p>An observation on 02/04/2025 at 2:13 PM revealed Resident #103's feeding tube pump had splatters on the sides and underneath in the same color (beige) as the resident's tube feeding formula.</p> <p>An observation on 02/07/2025 at 9:33 AM revealed tube feeding formula was on the floor under Resident #103's tube feeding pump and pole.</p> <p>An undated facility document titled, Housekeeper 4 {4} Daily Job Routine revealed, 7:30 [AM] Do morning walk-through of your area addressing spills. The document indicated housekeepers completed a 7 Step Room Cleaning that included 3. Spot Clean Vertical Surfaces and 7. Mop Floor. The document directed housekeeping staff to clean specific rooms using the 7 step method daily, including Resident #103's room.</p> <p>During an interview on 02/07/2025 at 9:37 AM, Registered Nurse (RN) #26 acknowledged the tube feeding formula on the resident's tube feeding pump and floor and stated housekeeping needed to clean it.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Interim Director of Nursing (IDON) and the Administrator on 02/07/2025 at 3:22 PM, the IDON stated tube feeding formula spills should be cleaned by the nurses and Certified Nurses Aides (CNA), or any staff member that saw the spills; however, the IDON said housekeeping staff should not clean the tube feeding pump when it was in use.</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52224</p> <p>Based on observation, record review, facility document and policy review, and interview, the facility failed to ensure facility staff honored a resident's right to be free from a physical restraint that was not required to treat the resident's medical symptoms for 1 (Resident #386) of 3 residents reviewed for abuse. Specifically, a facility staff member picked up and carried Resident #386 off the smoking patio and back into the facility, thereby restricting the resident's freedom of movement when the resident attempted to grab another resident's cigarette.</p> <p>Findings included:</p> <p>The facility policy titled, Restraint Policy, dated 12/2024, indicated, Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. The policy also specified, Emergency use of restraints is permitted if their use is immediately necessary to prevent the resident from injuring himself/herself or others and/or to prevent the resident from interfering with life sustaining treatment, and no other less restrictive interventions are feasible. The Director of Nursing Services has the authority to order the use of emergency restraints. The Attending Physician must be notified of such use and the reason for the order.</p> <p>The State Operations Manual - Appendix PP definitions at F604 defined a physical restraint as, any manual method, physical, or mechanical device, equipment, or material that meets all of the following criteria:</p> <ul style="list-style-type: none"> - is attached or adjacent to the resident's body; - cannot be removed easily by the resident; and - restricts the resident's freedom of movement or normal access to his/her body. <p>The definitions at F604 also indicated, Manual method means to hold or limit a resident's voluntary movement by using body contact as a method of physical restraint.</p> <p>1. An Admission Record revealed the facility admitted Resident #386 on 01/30/2025. According to the Admission Record, the resident had a medical history that included diagnoses of Huntington's disease (a progressive inherited neurodegenerative disorder that affects the brain, causing uncontrolled movements, cognitive decline, and psychiatric symptoms), gastrostomy status, and anxiety disorder.</p> <p>An annual Minimum Data Set (MDS) with an Assessment Reference Date of 01/30/2025, indicated it was in progress.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Nursing Admission/Readmission Data Collection tool, dated 01/30/2025, revealed Resident #386 had the ability to express ideas and wants, had the ability to understand verbal content, did not use a mobility device, and did not require assistance to transfer, walk in room, walk in corridor, or walk on the unit. According to the tool, the resident's current weight was 77.4 pounds and the resident's level of consciousness was alert and oriented to person, place and time. The tool indicated the resident did not use restraints, had adequate hearing and vision, and did not exhibit any verbal or physical behaviors in the last 14 days or have a history of harming self or others.</p> <p>Resident #386's Care Plan included a focus area initiated 01/30/2025 that indicated the resident was a smoker. Interventions directed staff to keep smoking materials secured and to encourage smoking per facility protocol (initiated 01/30/2025).</p> <p>An Initial Report dated 01/31/2025 indicated the facility admitted Resident #386 to the facility on [DATE] and informed the resident about the smoking policy. The report indicated a skin assessment completed on 01/30/2025 noted bruises and scratches to the resident's arms, but that the resident reported to the Administrator that the bruises resulted from being manhandled by staff on 01/31/2025. The report indicated the resident had displayed agitation when the resident went behind the nurse's station to get a cigarette and required staff redirection. The report indicated that the resident then went to the smoking patio and tried to take a lit cigarette from another resident, and a certified medication technician (CMT) wrapped their arms around the resident to keep the resident from harming another resident or harming self. The report revealed that the resident tried to get on the elevator but was redirected. The report indicated the CMT provided the facility with a written statement and was suspended pending the outcome of the investigation.</p> <p>On 02/03/2025 at 12:06 PM, Resident #386 was observed ambulating independently on the second floor secure unit, with an unidentified staff member providing one-to-one monitoring. During an interview at this time, Resident #386 stated that at another facility (prior to admission to this facility), a staff member had manhandled them, causing bruises and scratches on both arms. During the interview, Resident #386 showed their arms to the surveyor, but no bruises were visible. Resident #386 then stated the incident occurred at the current facility over the weekend. The surveyor asked Resident #386 to clarify which weekend and what day of the weekend this occurred. Resident #386 stated, The weekend. The surveyor asked Resident #386 what time the incident occurred, and Resident #386 stated, In the morning. Resident #386 further stated that they were new to the facility, and staff on the third floor grabbed the resident's arms and threw the resident on the bed. Resident #386 stated they did not know the names of the staff. The resident stated this incident occurred on the third floor and after it occurred, the resident was moved to the second floor. The resident also stated that they reported the incident to the nurse on the second floor and then told the Administrator, who said the incident would be investigated.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/04/2025 at 3:11 PM, Licensed Practical Nurse (LPN) #1 stated Resident #386 was moved to the second floor on 02/01/2025 around 10:30 AM, before lunch and before the 11:30 AM smoke break. LPN #1 stated that after the 11:30 AM smoke break, Resident #386 asked him/her to get a sandwich the resident had left on the third floor, and when LPN #1 returned with the sandwich, the resident stuck their wrists out and told LPN #1 that staff on the third floor grabbed the resident and threw them on the bed. LPN #1 stated that the resident's wrists were both red and had old bruising but did not have the color of fresh bruising. The resident reported to LPN #1 that they were aggressive with third floor staff and that third-floor staff were aggressive to them. LPN #1 stated he/she then called the Administrator to notify him/her of the resident's allegation. He/She stated the ADM instructed him/her to write a statement and place Resident #386 on one-to-one monitoring.</p> <p>During a telephone interview on 02/05/2025 at 9:37 AM, CMT #5 stated he/she worked the 6:45 AM - 2:45 PM shift on 02/01/2025 and met Resident #386 for the first time that day. CMT #5 stated that during the shift, Resident #386 asked LPN #2 for a cigarette. The nurse gave the resident a cigarette, and the resident went to the smoking patio and smoked it. After the resident completed the cigarette, the resident tried to take Resident #64's cigarette. Resident #64 tried to keep the cigarette from Resident #386, but the resident stood over Resident #64 and continued to try and take it. CMT #5 stated when the resident would not stop trying to take Resident #64's cigarette, the only other option was to pick the resident up and bring the resident inside. CMT #5 stated he/she did not see any physical contact between the residents, but when Resident #386 would not stop trying to take Resident #64's cigarette, CMT #5 opened the patio door, grabbed Resident #386 by the waist from behind, picked the resident up, and put the resident back inside. CMT #5 stated Resident #386 was a small-framed resident and when he/she picked the resident up, he/she carried the resident inside about five feet and put the resident down on their feet. CMT #5 stated he/she blocked the patio door because the resident kept trying to go back outside. CMT #5 stated he/she received a phone call from the Administrator around 1:30 PM and was told to write a statement, clock out, and go home. The CMT denied that he/she threw the resident in bed or grabbed the resident by the wrists.</p> <p>During a telephone interview on 02/05/2025 at 10:30 AM, Certified Nursing Assistant (CNA) #4 stated on 02/01/2025, an incident occurred around 9:30 AM when staff tried to get Resident #386 to calm down. CNA #4 stated he/she was at the nurse's desk charting when Resident #386 tried to go out to smoke and tried to take a cigarette from Resident #64. CNA #4 stated staff went outside, and CMT #5 grabbed Resident #386 around the waist, picked the resident up, and carried the resident back inside while the resident snatched, grabbed, punched, and swung their hands at staff. CNA #4 stated that once the resident was back inside, they calmed down, then CMT #5 and CNA #4 walked with the resident to the resident's room, but on the way to the resident's room, the resident turned around to go back toward the door, so CMT #5 picked the resident up from behind by the waist again, carried the resident to the resident's room, and sat the resident on the bed. CMT #5 asked the resident to calm down and to come out of the room once they calmed down, and staff then left the room. CNA #4 stated staff were trained not to put their hands on residents. CNA #4 stated that when CMT #5 carried the resident inside from the smoking patio, the distance was a few feet, and the second time CMT #5 picked the resident up to take them to the room, the distance was the width of one resident's room. During a follow-up telephone interview on 02/07/2025 at 10:35 AM, CNA #4 stated that if a resident became combative, it would be best to walk away and go get the nurse but not to pick up the resident.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/05/2025 at 3:46 PM, LPN #2 stated that on 02/01/2025 around 9:30 AM, Resident #386 came to the nurse's desk and asked for a cigarette. He/She gave the resident a cigarette, and the resident went to the third-floor smoking patio to smoke. LPN #2 stated that when the resident came back into the third-floor dining room, the resident asked for cigarettes to smoke again. LPN #2 stated he/she told the resident to wait until the next smoke break, and Resident #386 came around the nurse's desk and took the cigarette box. LPN #2 stated he/she was able to retrieve the cigarette box, but then Resident #386 went back to the smoking patio and physically tried to take a lit cigarette from Resident #64. LPN #2 stated that CMT #5 went onto the smoking patio and told the resident not to take the cigarette from Resident #64. LPN #2 stated he/she went onto the smoking patio to help, held the door open, and witnessed CMT #5 put his/her hands around Resident #386's waist from behind and walk the resident back inside.</p> <p>During an interview on 02/06/2025 at 8:46 AM, the Interim Director of Nursing (IDON) stated he/she looked through the facility's investigation on 02/03/2025, and he/she did not believe CMT #5's intention was to abuse or harm the resident but felt the CMT was trying to deescalate the situation. The IDON indicated the CMT could have stood between the residents, grabbed another staff member to help redirect, or offered food or medicine and try to get to the root cause of why the resident was so upset.</p> <p>During an interview on 02/06/2025 at 10:03 AM, the Administrator stated during his/her investigation, he/she spoke with CMT #5, who stated that Resident #386 tried to take a cigarette from Resident #64 during a smoke break on the third-floor patio and would not stop when asked by Resident #64 and by staff to stop. The Administrator stated that CMT #5 reported he/she then lifted the resident up by the waist and brought the resident back inside but denied that he/ threw the resident on the bed. The Administrator stated CMT #5 said he/she just picked Resident #386 up by the waist and brought them back inside for redirection, to keep them from taking the cigarette from Resident #64, and to prevent anything from happening to Resident #64. The Administrator stated that during his/her investigation, it was determined that CMT #5 did not intend to abuse or harm Resident #386, but that when he/she picked Resident #386 up, he/she violated the resident's right to move independently and the right not to be physically redirected to a different space. The ADM stated CMT #5's response to the resident was a poor method of redirection.</p> <p>During a telephone interview on 02/07/2025 at 10:46 AM, CMT #6 stated that he/she worked the 7:00 AM to 3:00 PM shift on the third floor on 02/01/2025. He/She did not witness the incident involving Resident #386 and Resident #64 but stated he/she witnessed Resident #386 cursing and yelling when CMT #5 walked the resident to their room. CMT #6 stated that when CMT #5 walked Resident #386 to their room, CMT #5 held the resident by the shoulders as they walked. CMT #6 denied witnessing CMT #5 pick the resident up. CMT #6 stated that if he/she witnessed a staff member pick up a resident, he/she would report this to the Director of Nursing, the Administrator, or the nurse. CMT #6 indicated that staff were not trained to pick up a resident or put hands on them. CMT #6 also stated, If they [residents] are able to walk and you pick them up, now they can't walk. That's a restraint and we can't put them in a restraint, period. They would not be walking on their own.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow-up interview on 02/07/2025 at 11:39 AM, the IDON read the facility's Restraint Policy and stated he/she agreed with the definition of a restraint as recorded in the policy. The IDON stated that a restraint would be anything hindering a resident's ability to move about freely. He/She stated in an emergency, the nurse would need to alert the DON, and the DON could give the authority for restraint use, and the attending physician would have to be notified and would need to sign orders within 48 hours of the emergency. The IDON stated that in his/her opinion, when CMT #5 picked Resident #386 up, that was a poor choice but did not meet the definition of a restraint because the resident was let go and their arms and legs remained free. When asked if the IDON agreed that Resident #386 could ambulate independently prior to being picked up by staff but could not do so while being carried by CMT #5, he/she stated that the resident could not ambulate when they were picked up by staff, but that this was a poor choice, not a restraint. The IDON stated staff were expected to use other means to intervene like moving other residents away from an aggressive resident or attempting to corral the aggressive resident elsewhere, trying to talk to the aggressive resident to diffuse the situation, or trying to get the focus of the aggressive resident on staff rather than on everybody else. The IDON stated the expectation would be for staff to deescalate the situation by staying calm, making eye contact with the aggressive resident, and talking with the resident in a calm voice, while other staff moved other residents away from the situation to avoid any harm.</p> <p>During a follow-up interview on 02/07/2025 at 12:33 PM, the Administrator read the definition of a restraint per the facility policy and stated that he/she agreed with the definition. The Administrator stated that if a resident could not remove a device applied by staff or anything that restricted the resident's physical ability to move, that would be considered a restraint and would require an assessment, documentation in the medical record, and a physician's order prior to its use. The Administrator stated CMT #5 used poor judgement and that he/she did not agree with the way CMT #5 handled the situation, as the resident had the right to move on their own and not be redirected to a different place. The Administrator stated that CMT #5 should have used better techniques to deescalate the situation, like telling Resident #386 the goals and why the resident should calm down. The Administrator stated that he/she would expect CMT #5 to avoid putting his/her hands on a resident and to redirect the resident with verbal cues and guide the resident in a safe direction.</p> <p>MO00248912</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>28193</p> <p>Based on interview, record review, and facility document and policy review, the facility failed to thoroughly investigate 1 of 3 entity self-reported incidents reviewed. Specifically, the facility failed to thoroughly investigate an incident involving a missing resident (Resident #96).</p> <p>Findings included:</p> <p>A facility policy titled, Abuse, Prevention and Prohibition Policy, revised 10/2022, revealed the section titled Investigation, included, The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. The policy further revealed, Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. If the allegation occurred on a specific shift, all staff for the identified shift only will complete a questionnaire and complete a statement if indicated. The policy revealed the facility was to Complete the investigation summary of statements and summary of investigation within five business days.</p> <p>1. Resident #96's Admission Record indicated the facility admitted the resident on 03/25/2024. According to the Admission Record, the resident had a medical history that included diagnoses of orthopedic aftercare following surgical amputation, assistance with personal care, muscle weakness, abnormalities of gait and mobility, alcohol abuse, and psychoactive substance abuse.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/27/2024, revealed Resident #96 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS further indicated the resident used a manual wheelchair for locomotion independently. The MDS revealed the resident was independent with eating, oral hygiene, and toileting hygiene. The MDS revealed the resident required supervision or touching assistance with showering/bathing and personal hygiene and required setup or clean-up assistance with upper and lower body dressing.</p> <p>Resident #96's care plan included a focus area initiated 01/12/2025, that indicated the resident had a current diagnosis of a substance use disorder related to alcoholism and had been leaving the facility, drinking, and returning inebriated. Interventions (initiated 01/12/2025) directed staff to allow one-on-one time to discuss behaviors and reasons for use of alcohol in a non-judgmental way; to ask the resident if they have ingested medications or drugs that were not prescribed to them; to assess and support respiratory and cardiovascular function; to assess mental status and determine if there was a change from the resident's baseline; and to assess the resident for the following symptoms and report as they present: stumbling, nodding off mid-conversation, incoherent speech, slurred speech, rambling, sleepy, erratic behavior, hyperactive, threatening, hostile, bloodshot eyes, pinpoint pupils, pale face sweaty unruly appearance, fumbling, nervous, jerky movements, and eating candy or sweets.</p> <p>A sign-out sheet used by Resident #96 to leave the facility on 01/24/2025 revealed the resident placed their initials on the sheet and identified a date of 1-26. The sheet revealed the resident had marked the Time Out to be 10:40 AM. The sheet revealed that the resident did not fill out the Time Planned to Return and marked the Visit Location to be the library.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/04/2025 at 12:40 PM, the Administrator stated Resident #96 had signed out at 10:40 AM on 01/24/2025 to go to the Downtown Library and had not returned. He/She stated the resident had dated the sign-out sheet for 01/26/2025; however, the date was 01/24/2025.</p> <p>Resident #96's Progress Notes, revealed a Health Status Note, dated 01/25/2025 at 11:35 PM, that indicated Resident #96 had left the facility the day before and still had not returned. The note revealed the Administrator and unit manager were notified and had asked staff to look for the resident throughout the facility. The note revealed that when Resident #96 was not found, the Administrator notified the police, who came to the facility to ask questions, obtained a Face Sheet, and called the local hospital. The note revealed the police notified the Administrator the resident had been discharged from the hospital around 11:30 PM (the evening prior). The note revealed the police left an emergency number with instructions to call and have the resident's name removed from the missing persons list if they arrived back at the facility. The note revealed Resident #96's Nurse Practitioner (NP) was notified and asked to be notified if the resident returned to the facility.</p> <p>Resident #96's Progress Notes revealed a Health Status Note dated 01/28/2025 at 7:53 PM, that indicated Resident #96 had returned to the facility with another person. The note revealed the person that accompanied Resident #96 back to the facility stated they found the resident wandering around 39th and Main [street] and Resident #96 asked for a ride back to the facility. The note revealed this person pushed Resident #96 in the wheelchair from 39th street to the facility. The note revealed Resident #96 was alert, not in distress, and had no complaints of pain or discomfort. The note revealed the resident's clothes were visibly soiled, so staff assisted to get the resident toileted, changed, and offered them snacks and fluids. The note revealed the resident had no recollection of being gone for four days. The note revealed Resident #96's physician and NP were notified of the resident's safe return.</p> <p>During an interview on 02/05/2025 at 1:30 PM regarding investigative efforts into the event involving Resident #96, the Administrator stated, There are no other interviews written anywhere, or additional information. He/She stated, Every incident that is called into the State [Survey Agency] has an initial investigation and then we have to send in our final five-day investigation for each one as well. He/She stated, All the information for that incident is in the folder I gave to you.</p> <p>A folder containing a copy of the investigation completed for Resident #96 included an initial report submitted to the State Survey Agency (SSA); the sign-out sheet filled out by Resident #96 prior to the leave of absence; timelines to show the dates and times phone calls were placed to the police, local hospitals, detention centers, and jails; and the in-service sign-in sheets for the education provided on the sign-out process for residents given to the staff following Resident #96's departure from the facility. No interviews from staff or residents were present in the folder presented as the investigation, and a follow-up five-day final report was not completed or submitted to the SSA for this incident.</p> <p>During an interview on 02/07/2025 at 10:17 AM, the Administrator stated, In hindsight, I should have interviewed everyone. We are learning, and no one has ever said anything about that [interviewing everyone] before. He/She also stated, Any incidents that we send into the State [Survey Agency] should have an initial investigation and a final five-day investigation sent in for each.</p> <p>MO00248567</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>42192</p> <p>Based on interview and record review, the facility failed to ensure Level I Preadmission Screening and Resident Reviews (PASRRs) were completed when 2 (Resident #45 and Resident #23) of 4 residents reviewed for PASRR requirements were diagnosed with new mental disorders.</p> <p>Findings included:</p> <p>During an interview on 02/07/2025 at 1:53 PM, the Administrator stated the facility did not have a policy that addressed the completion of PASSRs.</p> <p>1. Resident #45's Admission Record indicated the facility admitted the resident on 01/13/2017. According to the Admission Record, the resident had a medical history that included diagnoses of paranoid schizophrenia. The Admission Record indicated an additional diagnosis of recurrent major depressive disorder was added on 06/24/2024.</p> <p>Resident #45's Level One Nursing Facility Pre-Admission Screening for Mental Illness/Mental Retardation or Related Condition, dated 01/12/2017, indicated the resident was diagnosed with a major mental disorder, specifically schizophrenia, paranoia type. The screening indicated the resident did not have any serious problems with their level of functioning in the six months prior to the screening and had not received intensive psychiatric treatment in the prior two years. According to the results of the screening, the resident did not require a PASRR Level II evaluation.</p> <p>Resident #45's care plan included a focus area, initiated 04/27/2018 and revised 04/22/2024, that indicated the resident had behaviors related to a diagnosis of schizophrenia. The care plan also included a focus area, initiated 08/29/2022 and revised 04/22/2024, that indicated the resident was at risk for depression due to history of voicing feeling depressed.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/06/2024, revealed Resident #45 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. According to the MDS, at the time of the assessment, Resident #45 had active diagnoses that included depression and schizophrenia.</p> <p>Resident #45's medical record revealed no documented evidence a new PASRR was completed when Resident #45 was diagnosed with major depressive disorder.</p> <p>During an interview on 02/07/2025 at 1:53 PM, the Administrator and Interim Director of Nursing (IDON) stated Resident #45's PASRR should have been updated.</p> <p>46258</p> <p>2. An Admission Record revealed the facility admitted Resident #23 on 06/25/2021. According to the Admission Record, the resident had a medical history that included diagnoses of major depressive disorder (onset 02/01/2023) and psychotic disorder with delusions (onset 3/15/2023).</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #23's Level One Nursing Facility Pre-Admission Screening for Mental Illness/Mental Retardations or Related Condition, dated 01/04/2013, indicated Resident #23 had not been diagnosed with a major mental disorder.</p> <p>A Psychiatric Periodic Evaluation, dated 06/14/2022, indicated Resident #23 was evaluated for follow-up for medication management for potential psychiatric conditions. The evaluation indicated the resident was diagnosed with major depressive disorder.</p> <p>A Psychiatric Periodic Evaluation, dated 03/28/2023, indicated Resident #23 had a Chief Complaint of Depression. The evaluation indicated the resident was diagnosed with major depressive disorder and delusional thoughts.</p> <p>Resident #23's Care Plan Report included a focus area, initiated 03/27/2023, that indicated the resident had symptoms of depression.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/20/2024, revealed Resident #23 had a Brief Interview for Mental Status (BIMS) score 12, which indicated the resident had moderately impaired cognition. According to the MDS, at the time of the assessment, the resident had active diagnoses that included psychotic disorder and depression.</p> <p>Resident #23's medical record revealed no documented evidence the facility completed a new PASRR after the resident was diagnosed with major depressive disorder or psychotic disorder.</p> <p>During an interview on 02/07/2025 at 1:53 PM, the Administrator and Interim Director of Nursing (IDON) stated Resident #23's PASRR was not updated when Resident #23 received new major mental illness diagnoses.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>28193</p> <p>Based on interview, record review, and facility policy review, the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and timeframes to meet a resident's mental and psychosocial needs for 1 (Resident #73) of 2 residents reviewed for mood/behavior.</p> <p>Findings included:</p> <p>A facility policy titled, Trauma Informed Care, approved 12/2024, revealed, It is the policy of this facility to consider residents past traumatic experiences in developing person-centered care plans designed to avoid re-traumatization through the application of the principles of trauma-informed care. The policy revealed, Trauma: Informed Care: An approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma; recognizing the widespread impact and signs and symptoms of trauma; and avoiding re-traumatization. The policy further revealed, Procedure: Identification of Trauma Survivors included During the admission/intake process, residents and/or residents' representatives are given the voluntary opportunity to answer questions regarding trauma and to discuss their experiences to the extent they are comfortable. The policy revealed, Care Planning for Trauma Survivors, included, - Interdisciplinary staff work together with the resident/resident's representatives to assess the resident's needs and to identify triggers that may cause the survivor to remember the traumatic event and induce a reaction similar to when the resident was originally traumatized. - Care plan should describe the resident's cultural preferences, values, and practices and include approaches to meet the resident's cultural needs. - Care plan should describe interventions which consider the resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization and psychosocial harm. - Care plans are reviewed and revised as needed on at least a quarterly basis.</p> <p>1. Resident #73's Admission Record indicated the facility admitted the resident on 05/29/2024. According to the Admission Record, the resident had a medical history that included diagnoses of psychotic disorder not due to a substance or known physiological condition, anxiety, insomnia, post-traumatic stress disorder (PTSD), major depressive disorder with severe psychotic symptoms, and schizophrenia.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/04/2024, revealed Resident #73 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident was independent with all activities of daily living. The MDS revealed the resident had diagnoses of anxiety disorder, depression, psychotic disorder, schizophrenia, PTSD, other psychiatric disorder not due to a substance, and insomnia. The MDS revealed the resident was taking antipsychotic and antidepressant medications during the assessment lookback period.</p> <p>Resident #73's care plan revealed there was no focus area related to the diagnosis of PTSD.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Psychiatric Periodic Evaluation dated 08/27/2024 revealed Resident #73 had a history of PTSD stemming from childhood abuse by a nanny and reports associated memory problems. The evaluation revealed the resident expressed intermittent anxiety and ongoing nightmares related to the childhood trauma and had been treated for PTSD in the past, with current treatment including Lexapro, mirtazapine, trazodone, and Abilify. Recommendations revealed, Pt [patient] can benefit from the behavioral modification strategies. Nursing care plan for this recommended.</p> <p>During an interview on 02/06/2025 at 9:07 AM, Certified Nursing Assistant (CNA) #18 stated he/she was unaware of Resident #73 having a diagnosis of PTSD.</p> <p>During an interview on 02/06/2025 at 9:19 AM, CNA #19 stated Resident #73 did not have a diagnosis of PTSD that he/she knew of.</p> <p>During an interview on 02/06/2025 at 11:09 AM, the MDS Registered Nurse (RN) stated care plans were triggered by the admission assessments and baseline care plans completed. He/She stated they were set up to auto feed into a care plan based on triggers within the system. He/She stated he/she did not know Resident #73 well, but did know the resident had a diagnosis of PTSD. The MDS RN acknowledged there was no care plan generated to address Resident #73's diagnosis of PTSD. He/She stated he/she was responsible for the oversight of the care plans, and it was too much to keep up with. He/She stated he/she relied on what others put into the computer to be accurate, and there were a lot of things that might not be right or not have care plans that should be care planned.</p> <p>During an interview on 02/07/2025 at 10:40 AM, the Interim Director of Nursing (IDON) stated residents with a diagnosis of PTSD needed to have their triggers listed on their care plan so that staff knew what they were. He/She stated staff should know how to approach the residents as to not create behaviors as well as how to de-escalate a situation when it should arise.</p> <p>During an interview on 02/07/2025 at 10:42 AM, the Administrator stated his/her expectation was for staff to complete care plans per the facility policy. The Administrator stated staff should know how to care for residents with a diagnosis of PTSD and how to approach them without triggering them.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28193</p> <p>Based on interview, record review, and facility document and policy review, the facility failed to provide adequate supervision for 1 (Resident #96) of 6 residents reviewed for accidents.</p> <p>Findings included:</p> <p>A facility policy titled, Signing Residents Out, reviewed by the facility 10/2022, indicated, 1. Each resident leaving the premises (excluding transfers/discharges) must sign out or be signed out. 2. A sign-out log is located in designated areas within the facility. Logs will include the following: - Resident Name - Person Name accompanying resident if resident is not taking self out - Date and Time leaving - Date and Time of anticipated return - If anticipated return date and time is not documented on the log, the facility will initiate the steps after 4 hours of the residents signing out - Where the resident is going - Date and Time of Return - Signature of responsible party or resident 3. Resident or person accompanying the resident will sign resident back into the community upon return and notify the nurse [sic] 4. In the event there is inclement weather (rain, snow, extreme temperatures)facility [sic] staff will educate the resident on the risks of exposure and encourage them to wait until the weather is favorable. 5. If the resident does not return within an hour of anticipated return time, the community will initiate the following process until resident is contacted. - Notify Administrator and DON [Director of Nursing] - Contact the resident or person accompanying resident if have known phone number - Contact the location the resident was going - Contact the resident representative - Notify Provider - Contact Local Emergency Department - Notify Local Police Department. The policy revealed, 6. Staff observing a resident leaving the premises, [sic] and having doubts about the resident being properly signed out, should notify their supervisor at once.</p> <p>Resident #96's Admission Record indicated the facility admitted the resident on 03/25/2024. According to the Admission Record, the resident had a medical history that included diagnoses of orthopedic aftercare following surgical amputation, assistance with personal care, muscle weakness, abnormalities of gait and mobility, alcohol abuse, and psychoactive substance abuse.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/27/2024, revealed Resident #96 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS further indicated the resident used a manual wheelchair for locomotion independently. The MDS revealed the resident was independent with eating, oral hygiene, and toileting hygiene. The MDS revealed the resident required supervision or touching assistance with showering/bathing and personal hygiene and required setup or clean-up assistance with upper and lower body dressing.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Resident #96's care plan included a focus area initiated 01/12/2025, that indicated the resident had a current diagnosis of a substance use disorder related to alcoholism and had been leaving the facility, drinking, and returning inebriated. Interventions (initiated 01/12/2025) directed staff to allow one-on-one time to discuss behaviors and reasons for use of alcohol in a non-judgmental way; to ask the resident if they have ingested medications or drugs that were not prescribed to them; to assess and support respiratory and cardiovascular function; to assess mental status and determine if there was a change from the resident's baseline; and to assess the resident for the following symptoms and report as they present: stumbling, nodding off mid-conversation, incoherent speech, slurred speech, rambling, sleepy, erratic behavior, hyperactive, threatening, hostile, bloodshot eyes, pinpoint pupils, pale face sweaty unruly appearance, fumbling, nervous, jerky movements, and eating candy or sweets. The care plan revealed a focus area initiated on 03/26/2024, that indicated Resident #96 had an activity of daily living self-care performance deficit. Interventions (revised 12/30/2024) directed staff that the resident was able to reposition themselves, allow sufficient time for dressing and undressing with assistance for lower body dressing at times, the resident could feed themselves, brush their teeth, wash their hand, wipe self and adjust clothing independently, take themselves to the bathroom, transfer independently, and self-propel in the wheelchair.</p> <p>Resident #96's Order Summary Report, with active orders as of 02/07/2025, revealed an order dated 01/09/2025 for May go LOA [leave of absence] independently without meds [medications].</p> <p>Resident #96's Progress Notes, revealed a Health Status Note dated 01/25/2025 at 11:35 PM, that indicated Resident #96 had left the facility the day before and still had not returned. The note revealed the Administrator and unit manager were notified and had asked staff to look for the resident everywhere in the facility. The note revealed that when Resident #96 was not found, the Administrator notified the police, who came to the facility to ask questions, obtained a Face Sheet, and called the local hospital. The note revealed the police notified the Administrator the resident had been discharged from the hospital around 11:30 PM (the evening prior). The note revealed the police left an emergency number with instructions to call and have the resident's name removed from the missing persons list if they arrived back at the facility. The note revealed Resident #96's Nurse Practitioner (NP) was notified and asked to be notified if the resident returned to the facility.</p> <p>A sign-out sheet used by Resident #96 to leave the facility on 01/24/2025 revealed the resident placed their initials on the sheet and identified a date of 1-26. The sheet revealed the resident had marked the Time Out to be 10:40 AM. The sheet revealed that the resident did not fill out the Time Planned to Return and marked the Visit Location to be the library.</p> <p>On 02/05/2025 at 2:45 PM, the Administrator provided the name of the library Resident #96 went to frequently. The library website revealed they closed at 6:00 PM on Fridays.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/04/2025 at 12:40 PM, the Administrator stated Resident #96 had signed out at 10:40 AM on 01/24/2025 to go to the Downtown Library and had not returned. He/She stated the resident had dated the sign-out sheet for 01/26/2025; however, the date was 01/24/2025. The Administrator stated an Assistant Director of Nursing (ADON) was made aware by the evening shift nurse that Friday night (01/24/2025) Resident #96 had not returned from the library, but he/she was unsure of the exact time and would have an ADON answer to that. The Administrator stated Licensed Practical Nurse (LPN) #7 notified him/her on 01/25/2025 at 9:07 AM that Resident #96 had not returned to the facility. The Administrator called the Regional Director of Operations (RDO), and phone calls to the police department, local hospitals, detention centers, and jails were started. The Administrator stated that just prior to lunch, the police notified him/her that Resident #96 had been to the ER (emergency room), got violent with the nurses, and left AMA (against medical advice). The Administrator stated when he/she called the hospital to get a full report, he/she was told the resident was verbally aggressive and left the ER to get a cab and go to a hotel. The Administrator stated during the afternoon on 01/25/2025, he/she went to the facility and started education on what should be written in the sign-out books going forward and when to respond or act and stated the facility did have a policy regarding residents signing in and out of the facility. The Administrator stated the decision to report the incident to the State Agency was made because he/she was told it was the facility's policy to report a resident who left and choose to not return, and he/she was guided by her RDO to report to the State Agency. He/She stated they reported the incident not as an elopement, but as a person that did not return. He/She stated that per their regional office, their guidance was to report a person that did not return to the facility, even after signing themselves out. The Administrator stated an interim Director of Nursing (IDON) from the corporate office was covering the building; however, there was no on-site DON during the time of this incident. The Administrator stated that he/she made the IDON aware Resident #96 had not returned to the facility right after he/she was notified on Saturday morning (01/25/2025).</p> <p>During an interview on 02/06/2025 at 3:01 PM, Certified Medical Technician (CMT) #8 stated it was supper time (on Friday 01/24/2025) and Resident #96 was not at the table ready to eat. He/She stated that he/she went to the resident's room, checked the bathroom, and looked all over the third floor in places the resident would normally go. He/She stated that when he/she could not find Resident #96, she/he told the floor nurse, who was an agency nurse and was unsure exactly what to do. CMT #8 stated he/she then called the Staffing Coordinator, who was the manager on call for the weekend. CMT #8 stated he/she saw the resident had signed out to go to the library that morning and relayed that to the Staffing Coordinator. He/She stated that while the Staffing Coordinator was on the phone with an ADON, letting him/her know, he/she called the Administrator and told him/her Resident #96 had not returned from the library. CMT #8 stated the Administrator told him/her to go check the sign-out books as well, and no further instructions were given to him/her that evening. CMT #8 stated Resident #96 did not return to the facility during the remainder of the shift.</p> <p>During a telephone interview on 02/05/2025 at 11:08 AM, the Staffing Coordinator stated he/she received a phone call from CMT #8 between 6:30 PM and 7:00 PM on Friday (01/24/2025). The Staffing Coordinator stated CMT #8 said they had not seen Resident #96, so he/she had him/her check the sign-out books to see where the resident had gone. He/She stated that he/she then told CMT #8 that he/she would call an ADON and let him/her know. The Staffing Coordinator stated when he/she spoke to an ADON, the ADON gave the same instructions to check the sign-out book to see where Resident #96 had gone. The Staffing Coordinator stated the ADON did not give any other instructions or ask him/her to notify anyone else and stated he/she did not hear anything more about the situation again after that.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Highland Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 904 East 68th Street Kansas City, MO 64131	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/04/2025 at 12:53 PM, ADON #41 stated he/she received a call from the Staffing Coordinator at 7:00 PM on 01/24/2025 and was told CMT #8 had called and stated Resident #96 was not at the facility. ADON #41 stated he/she instructed the Staffing Coordinator to check both sign-out books and to call the Administrator and to keep him/her updated. He/She stated he/she did not hear from anyone else that night about Resident #96.</p> <p>During a telephone interview on 02/05/2025 at 11:15 AM, LPN #7 stated he/she had worked on Thursday (01/23/2025), and Resident #96 was at the facility. He/She stated he/she had Friday (01/24/2025) off and returned to work on Saturday (01/25/2025) for the dayshift. He/She stated when he/she arrived at work, he/she printed out the shower list for the day, and Resident #96 was on the list. LPN #7 stated the certified nursing assistant (CNA) working with him/her stated the resident was not there. LPN #7 stated an agency nurse had worked on Friday night (01/24/2025) and probably did not know the residents, so they did not know Resident #96 was not in the building. LPN #7 stated he/she sent the CNAs to look around the building for the resident room to room and all the places the resident liked to go when in the facility. He/She stated he/she saw the resident had signed out at 10:40 AM, but the date was written wrong. He/She stated he/she called the Administrator early on 01/25/2025 and told him/her the staff had looked around the building, and the resident had signed out the day before to go to the library. LPN #7 stated the police came to the building to ask questions and notified them Resident #96 went to the hospital and was discharged at 11:20 PM on Friday (01/24/2025) night but did not return to the facility. LPN #7 stated the police took a copy of Resident #96's Face Sheet and were going to do a street search and place the resident on the missing persons list. LPN #7 stated the police officer gave the facility an emergency phone number to call if the resident came back. He/She stated he/she was the nurse on duty when Resident #96 returned to the facility on [DATE], and called the phone number to let the police department know the resident had come back.</p> <p>Resident #96's Progress Notes revealed a Health Status Note dated 01/28/2025 at 7:53 PM, that indicated Resident #96 had returned to the facility with another person. The note revealed the person that accompanied Resident #96 back to the facility stated they found the resident wandering around 39th and Main [street] and Resident #96 asked for a ride back to the facility. The note revealed this person pushed Resident #96 in the wheelchair from 39th street to the facility. The note revealed Resident #96 was alert, not in distress, and had no complaints of pain or discomfort. The note revealed the resident's clothes were visibly soiled, so staff assisted to get the resident toileted, changed, and offered them snacks and fluids. The note revealed the resident had no recollection of being gone for four days. The note revealed Resident #96's physician and NP were notified of the resident's safe return.</p> <p>A Progress Note dated 01/28/2025 at 11:00 PM revealed a visit from Resident #96's NP. The note revealed the Chief Complaint was a visit after returning from leave. The note revealed Resident #96 went out to the library after signing out on 01/24/2025 via self-check-out and came back on 01/28/2025. The note revealed Resident #96 was intoxicated, sent to the ER, and then discharged to the street. The note revealed the resident was known to drink alcohol, refused treatment for alcoholic addiction, and was reported to be under the influence when they arrived back at the facility the day before; but that day was A&Ox3 [alert and oriented times three; person, place, and time], got out of bed, and was propelling their wheelchair. The note revealed It appears difficult to control the patient's alcoholism. The note revealed Resident #96 was Entitled to self-check-out. Refused AA [Alcoholics Anonymous] or other medical treatment for history of alcoholism.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/07/2025 at 10:25 AM, the Interim Director of Nursing (IDON) stated his/her expectation was if they had a missing person, the staff would check to see if the resident had signed out, and if the resident was not back within an hour of the return time, management would start calling family and any other contacts they could find. The IDON stated management would also call the police, detention centers, and hospitals.</p> <p>During an interview on 02/07/2025 at 10:17 AM, the Administrator stated his/her expectation, if a resident was missing, was for the staff to look at the sign-out log. The Administrator stated an hour after the time the resident said they were going to return, the staff were to contact her and the phone tree would begin with calling the location they said they were going to, calling the doctor and power of attorney, and start going place by place where the resident would go. He/She stated they should have acted sooner with Resident #96 and that was why he/she came in and provided more education to the staff after this incident on following the one-hour rule and ensuring the residents were filling out the sign out book completely.</p> <p>MO00248567</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>52219</p> <p>Based on interview, record review, and facility document and policy review, the facility failed to provide physician-ordered medications to meet the needs of 1 (Resident #339) of 1 resident reviewed for significant medication errors.</p> <p>Findings included:</p> <p>A facility policy titled, Admission Policy, approved 12/2024, revealed, Procedure: Prior to or at the time of admission, the resident's Attending Physician must provide the facility with information needed for the immediate care of the resident, including orders covering at least: b. Medication orders, including (as necessary) a medical condition or problem associated with each medication; and e. [sic] Routine care orders to maintain or improve the resident's function until the physician can care planning team can conduct a comprehensive assessment and develop a more detailed interdisciplinary Care Plan.</p> <p>A facility policy titled, 2.6A: Ordering Medications (Electronic), dated 05/2019, revealed, Policy: Medications and related products are ordered from [pharmacy vendor] on a timely basis. The policy revealed, Procedure: 1. New medication orders (excluding controlled substances) that are less than 140 characters are accomplished through the electronic medical record system. The entry is electronically transmitted and includes: - Date ordered - Name of medication, strength of medication, dosage, time or frequency of administration, route of administration, quantity or duration, and diagnosis or indications for use. New medication orders (excluding controlled substances) that are 140 characters or greater must be faxed to the pharmacy and must include: - Date ordered. - Name of medication, strength of medication, dosage, time or frequency of administration, route of administration, quantity or duration, and diagnosis or indications for use. The policy also indicated, 4. New medications needed prior to regular delivery. - Check your convenience and emergency box (Med [medication]-Dispense Unit). If the medication is available, use that supply for the first dose. If applicable, follow Controlled Substance Emergency Dispensing Kit (EDK) Usage Protocol.</p> <p>A facility policy titled, 5.2: Medication Administration, dated 05/2019, revealed the section titled Procedure, included, 23. If medication is ordered but not present, call the pharmacy or supervisor to obtain the medication.</p> <p>1. An Admission Record revealed the facility admitted Resident #339 on 01/31/2025. According to the Admission Record, the resident had a medical history that included diagnoses of hypothyroidism, hyperlipidemia, hypertension, and bradycardia.</p> <p>Resident #339's Discharge Medications list from their hospital admission beginning on 01/22/2025 revealed the resident's Updated Home Medication List included the following:</p> <p>-Amlodipine (a calcium channel blocker)10 milligrams (mg) were to be administered daily at 9:00 AM, and the last dose was administered on 01/31/2025 at 8:32 AM.</p> <p>-Levothyroxine (thyroid hormone) 50 micrograms (mcg) were to be administered daily at 9:00 AM, and the last dose was administered on 01/31/2025 at 5:34 AM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Lovastatin (statin to treat high cholesterol) 40 mg were to be administered daily at 9:00 AM and was not recorded as administered.</p> <p>-Metoprolol succinate XL (extended release) (a beta blocker to slow down the heart rate) 50 mg were to be administered daily at 9:00 AM, and the last dose was administered on 01/31/2025 at 8:32 AM.</p> <p>-The Discharge Medications list revealed, Above is the list of medications to take at home until told to stop doing so by your doctor.</p> <p>Resident #339's Order Summary Report, with active orders as of 02/07/2025, contained an order dated 01/31/2025, for amlodipine besylate oral tablet 10 mg with instructions to give one tablet by mouth one time a day hypertension (HTN). The Order Summary Report contained an order dated 01/31/2025, for metoprolol succinate ER (extended release) 24-hour 50 mg with instructions to give one tablet by mouth one time a day for HTN and to hold the administration of the medication if the resident's pulse was less than 60 beats per minute. The Order Summary Report contained an order dated 01/31/2025, for lovastatin oral tablet 40 mg with instructions to give one tablet by mouth at bedtime for HLD (hyperlipidemia). The Order Summary Report revealed an order dated 01/31/2025, for levothyroxine sodium oral tablet 50 mcg with instructions to give one tablet by mouth one time a day for hypothyroidism.</p> <p>Resident #339's February 2025 Medication Administration Record [MAR], revealed the following:</p> <ul style="list-style-type: none"> - Certified Medical Technician (CMT) #6 documented a code of 6 for the administration of lovastatin oral tablet 40 mg at bedtime on 02/01/2025. The MAR revealed a code of 6 meant Other - See Progress Notes. - CMT #22 documented a code of 6 for the administration of amlodipine 10 mg the mornings of 02/01/2025 or 02/02/2025. - CMT #22 documented a code of 6 for the administration of metoprolol succinate ER oral tablet 50 mg the mornings of 02/01/2025 and 02/02/2025. - Levothyroxine sodium oral tablet 50 mcg scheduled to be administered at 6:00 AM was blank for 02/01/2025, 02/02/2025, and 02/03/2025. The MAR revealed there was no code charted for each of the missed doses. <p>Resident #339's Progress Notes, revealed an Orders Administration Note, dated 02/01/2025 at 8:42 PM and entered by CMT #6, that indicated, Lovastatin Oral Tablet 40 MG Give 1 tablet by mouth at bedtime for HLD IN ROTUTE [sic].</p> <p>Resident #339's Progress Notes, revealed an Orders Administration Note, dated 02/01/2025 at 12:35 PM and entered by CMT #22, that indicated, amlodipine Besylate Oral Tablet 10 MG Give 1 tablet by mouth one time a day for HTN not in stock.</p> <p>Resident #339's Progress Notes, revealed an Orders Administration Note, dated 02/02/2025 at 12:33 PM and entered by CMT #22, that indicated, amlodipine Besylate Oral Tablet 10 MG Give 1 tablet by mouth one time a day for HTN not in stock.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #339's Progress Notes, revealed an Orders Administration Note, dated 02/01/2025 at 12:34 PM and entered by CMT #22, that indicated, Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG Give 1 tablet by mouth one time a day for HTN Hold if pulse is less than 60 not in stock.</p> <p>Resident #339's Progress Notes, revealed an Orders Administration Note, dated 02/02/2025 at 12:33 PM and entered by CMT #22, that indicated, Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG Give 1 tablet by mouth one time a day for HTN Hold if pulse is less than 60 not in stock.</p> <p>Resident #339's Progress Notes for the timeframe from 02/01/2025 to 02/03/2025 revealed no notes documenting a reason for the missed doses of levothyroxine for Resident #339.</p> <p>During an interview on 02/06/2025 at 6:11 PM, CMT #6 confirmed he/she worked on 02/01/2025 on the fourth floor for the second shift from 2:45 PM to 10:45 PM. CMT #6 did not recall entering the progress note or anything about Resident #339. CMT #6 stated if a medication were not available, he/she would order it through the electronic MAR. CMT #6 stated he/she would choose the action available on the electronic MAR to reorder a medication if the medication was not available. CMT #6 stated he/she would then enter a progress note to show the medication was en route from the pharmacy. CMT #6 stated he/she would notify the nurse if a medication was not available. CMT #6 stated the nurse would notify the doctor of the missing medication. CMT #6 could not recall who the nurse was that evening that he/she talked to about the missing medication.</p> <p>During an interview on 02/07/2025 at 10:09 AM, CMT #22 stated Resident #339's medications were not found on both carts and the medication room on both days (02/01/2025 and 02/02/2025). CMT #22 told a nurse about the missing medications on both days. CMT #22 could not recall the name of the nurses. CMT #22 stated that when a medication was not available, the CMTs let the charge nurse know. CMT #22 stated that when they informed the nurse and the nurse faxed the order to the pharmacy, the CMT would document in the MAR en route from pharmacy.</p> <p>During a follow-up interview on 02/07/2025 at 10:33 AM, CMT #6 stated the night nurse, not the CMTs, would administer levothyroxine.</p> <p>A Manifest: 4, dated 01/31/2025, revealed delivery of Resident #339's medications on 01/31/2025. The Manifest revealed delivery on 01/31/2025 of nine amlodipine 10 mg tablets, nine levothyroxine 50 mcg tablets, nine lovastatin 40 mg tablets, and nine metoprolol succinate ER 50 mg tablets. The Manifest revealed the Clinical Liaison signed the Manifest for the receipt of the medications on 01/31/2025 at 11:19 PM Central Standard Time (CST).</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/06/2025 at 6:27 PM, the Clinical Liaison confirmed working the night shift on 01/31/2025 and signing the Manifest for the delivery of Resident #339's medications on 01/31/2025. The Clinical Liaison stated that typically when medications were received, they would go on the cart (CMT cart). The Clinical Liaison stated he/she did not know which CMT cart to put Resident #339's medications in so the medications were left in the nurses' room (locked room at nurse station). The Clinical Liaison stated the oncoming nurse was notified of the medications in the nurses' room. The Clinical Liaison stated he/she told the oncoming nurse (Registered Nurse [RN] #23) of the receipt of Resident #339's medications and where they were located. The Clinical Liaison stated Resident #339's medications were not placed in the CMT's cart because Resident #339 was new to the facility and there was no spot in the cart for their medications. The Clinical Liaison stated that when medications were not available in the cart, the nurse could try the emergency kit to retrieve medication if available, and the nurse could fax the order to the pharmacy.</p> <p>During an interview on 02/07/2025 at 10:20 AM, RN #23 confirmed working the day shifts on 02/01/2025 and 02/02/2025. RN #23 stated that when a medication was not available in the CMT's cart, the CMT should ask the nurse for the medication, and the nurse would reorder the medication by contacting the pharmacy. RN #23 stated the physician would only be called if the resident was missing a narcotic. He/She stated that when the medication was a house stock medication such as Tylenol, then it would be in the medication room. RN #23 stated he/she did not remember being asked by CMT #22 on either morning for Resident #339's missing medications and stated if medications were not available, he/she would have taken care of it.</p> <p>During an interview on 02/07/2025 at 5:14 PM, Licensed Practical Nurse (LPN) #24 stated that she worked on 02/01/2025 and 02/02/2025. LPN #24 stated RN #23 did not inform him/her of medications not being available for administration or the medications delivered by the pharmacy for Resident #339. LPN #24 stated RN #23 worked the shift prior to the shift he/she worked and then came back to relieve him/her from his/her shift. LPN #24 stated if he/she had been made aware of the medications not being available, he/she would have notified the pharmacy when he/she contacted the pharmacy about another resident's medications. LPN #24 stated he/she cleaned the nurses' cart and the treatment cart that weekend and did not see any medications on the carts for Resident #339. LPN #24 stated he/she did not go into the CMT carts and did not have access to the emergency kit because he/she was an agency nurse. LPN #24 stated nothing on the MAR flagged for Resident #339 because the CMTs would normally give all the medications except for the narcotics and the thyroid medication. He/She stated the CMTs would not administer the thyroid medication because it was a 6:00 AM medication. LPN #24 stated if he/she did not administer the thyroid medication, he/she would have told the CMT so they could administer the medication on their shift.</p> <p>During an interview on 02/07/2025 at 10:59 AM, the Nurse Practitioner (NP) stated that he/she was notified that Resident #339 missed ordered medications, and that the medications were delivered and available for administration. The NP stated he/she saw Resident #339 several times since admission. The NP stated he/she monitored Resident #339's blood pressure and it was around 130 (millimeters of mercury [mmhg]) systolic, and the NP had no concerns. The NP stated that when medication was not available, the nurse should go to the emergency kit or call the pharmacy. The NP stated once the medication was ordered, then the nurse or CMT would document en route since they were getting it delivered. The NP stated levothyroxine is administered by the nurse, not the CMT. The NP stated he/she ordered labs and the potential side effects of Resident #339 not receiving the medications would be sluggishness or tachycardia, or the resident's heart rate going up. He/She stated missing the medications would not jeopardize Resident #339's well-being and that Resident #339 was stable.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/07/2025 at 1:51 PM, Assistant Director of Nursing (ADON) #42 stated CMTs should tell the charge nurse when a medication was not available to administer. ADON #42 stated the nurse should call the pharmacy. ADON #42 stated not all nurses had access to the emergency kit; however, agency nurses would be able to ask somebody (a nurse on shift who was an employee). ADON #42 stated that on 02/03/2025 Resident #339 told him/her no medications were administered. ADON #42 stated the pharmacy confirmed the delivery of the medications on 01/31/2025. ADON #42 stated he/she found the medications in the bottom of the nurses' cart. ADON #42 stated the Clinical Liaison put the medications in the nurses' cart, and the medications should have been placed in the CMTs' cart.</p> <p>A list of medications found in the facility's emergency drug kit revealed lovastatin was not listed as a drug available to retrieve from the emergency drug kit. The list revealed five metoprolol succinate ER 25 mg tablets, five amlodipine 5 mg tablets, and five levothyroxine .05 mg tablets were available.</p> <p>During an interview on 02/06/2025 at 3:54 PM, the Interim Director of Nursing (IDON) confirmed metoprolol, amlodipine, and levothyroxine were not removed from the emergency drug kit on 02/01/2025 and 02/02/2025. The IDON confirmed lovastatin was not an available drug provided in the emergency drug kit.</p> <p>During an interview on 02/07/2025 at 3:04 PM, the IDON stated his/her expectation of CMTs was for them to go to the nurse when a medication was not available to administer, and the nurse would investigate and get the medication. The IDON stated the nurse could call the pharmacy or could check for the medication in the emergency kit. The IDON stated the nurse should call the doctor to let them know of the missed doses of medication. The IDON stated the medications should go into the CMT's medication cart. The IDON stated the nurses should have administered Resident #339's levothyroxine.</p> <p>During an interview on 02/07/2025 at 3:20 PM, the Administrator stated that when the medication was in the facility, the physician orders should be followed to administer that medication.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>52224</p> <p>Based on observations, interviews, and facility document and policy review, the facility failed to ensure food was prepared, stored, and served in accordance with professional standards for food safety as evidenced by the following: 1. Staff were not wearing beard guards to cover facial hair when in food preparation areas; 2. Food items, including sausage patties and chocolate chips, were not stored in closed containers; 3. Open food items, including preboiled eggs, diced pineapple, honey, and sausage gravy, were not dated; and 4. Residents' personal food items stored by the facility were not labeled with a resident's name and date and were not discarded when indicated. These failures had the potential to affect all 129 residents receiving meals from the dietary department at the time of the survey.</p> <p>Findings included:</p> <p>1. An undated facility policy titled, Hair Restraints indicated, 1. Staff shall wear hair restraints in all food production, dishwashing, and when serving food from steam or cold table areas. 2. Hair restraints, hats, and/or beard guards shall be used to prevent hair from contacting exposed food. Facial hair is discouraged. Any facial hair that is longer than the eyebrow shall require coverage with a beard guard in the production and dishwashing areas.</p> <p>An observation on 02/07/2025 at 8:34 AM revealed the Building Engineer entered the kitchen without using hair restraints to cover their long hair and long facial hair. While in the kitchen, the Building Engineer entered the food preparation area where there was an uncovered pot of oatmeal and an uncovered pan of scrambled eggs.</p> <p>During an interview on 02/07/2025 at 8:59 AM, the Building Engineer stated staff were expected to cover their hair and facial hair anytime they entered the kitchen. The Building Engineer stated he/she forgot to cover his hair when he/she entered the kitchen on the morning of 02/07/2025.</p> <p>The Dietary Manager (DM) was interviewed on 02/07/2025 at 8:45 AM. The DM stated he/she expected staff to wear hair restraints to cover hair on their head and their face.</p> <p>2. During a concurrent observation and interview on 02/03/2025 at 9:10 AM with Dietary Aide (DA) #32, an open box of frozen sausage patties, approximately three-fourths full, was observed in the freezer. The box was not closed, and the contents were open to air. DA #32 stated the box of sausage patties should have been closed.</p> <p>During a concurrent observation of the dry storage area and an interview on 02/03/2025 at 9:37 AM with the Dietary Manager (DM), a 25-pound box of chocolate chips was not closed, which exposed the contents to the air. The DM stated the box should have been closed.</p> <p>3. An undated facility policy titled, Food Storage (Dry, Refrigerated and Frozen) indicated, 1. General storage guidelines to be followed: a. All food items will be labeled. The label must include the name of the food and the date by which it shall be sold, consumed, or discarded.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Highland Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 904 East 68th Street Kansas City, MO 64131	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a concurrent observation of the walk-in refrigerator and an interview on 02/03/2025 at 9:15 AM with Dietary Aide (DA) #32 and the Dietary Manager (DM), eight boiled eggs wrapped in plastic wrap and a plastic container of diced pineapple were stored without a date to indicate when the items were prepared, opened, or when they should be discarded. The DM and DA #32 stated that each food item should be labeled with the date of storage.</p> <p>During a concurrent observation of the dry storage area and an interview on 02/03/2025 at 9:20 AM with the Dietary Manager (DM), an open package of peppered sausage gravy mix and five open bottles of honey were observed without a date to indicate when the items were opened or when they should be discarded. The DM stated the items should have been labeled with the dates they were opened.</p> <p>During an interview on 02/07/2025 at 9:12 AM, the Interim Director of Nursing (IDON) stated dietary staff were expected to date and label all foods with a label to record the date the food was made or opened prior to storing the food.</p> <p>52219</p> <p>4. A facility policy titled, Foods Brought by Family/Visitors, reviewed 01/2017, revealed, 5. Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name and dated. The policy also indicated, 6. The nursing and/or food service staff must discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, foul odor, past due package expiration dates).</p> <p>A concurrent interview and observation on 02/07/2025 at 8:29 AM of the fourth-floor dining room refrigerator revealed a pizza box not labeled with a name or date. Staff who were present did not know who the pizza belonged to. Certified Nursing Assistant (CNA) #17 said the pizza should have been labeled with the name of who it belonged to.</p> <p>During an interview on 02/07/2025 at 9:25 AM, Resident #98 stated they ordered the pizza on the evening of 02/06/2025.</p> <p>An observation of the refrigerator in the fourth-floor dining room on 02/07/2025 at 1:42 PM revealed a sandwich consisting of what appeared to be two pieces of bread and a jelly-like substance. The sandwich was inside a plastic bag labeled with a date of 01/03/2025 but no name to indicate who it belonged to. A small plastic container with a white substance inside was also observed inside the refrigerator without a label identifying what it was, when it was prepared, opened, or placed in the refrigerator, or who it belonged to.</p> <p>During an interview on 02/07/2025 at 1:48 PM, Assistant Director of Nursing (ADON) #42 stated that whoever placed items in the refrigerator was supposed to label the items with a name and date. ADON #42 stated he/she thought housekeeping was responsible for maintaining the items in the refrigerator but was not sure.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>52219</p> <p>Based on observation, interview, record review, facility document and policy review, and review of the Centers for Disease Control and Prevention (CDC) enhanced barrier precaution (EBP) signage, the facility failed to provide care in accordance with infection control standards for 2 (Resident #336 and Resident #103) of 9 residents reviewed for the infection control task. Specifically, the facility failed to ensure staff implemented enhanced barrier precautions (EBP), including appropriate hand hygiene and personal protective equipment (PPE) use, when providing care to Resident #336 and Resident #103. In addition, the facility failed to ensure Resident #336's indwelling urinary catheter drainage bag and tubing were not on the floor.</p> <p>Findings included:</p> <p>An undated facility policy titled, Infection Prevention and Control Manual - Enhanced Barrier Precautions revealed, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk for MDRO acquisition (such as residents that have wounds or indwelling medical devices). This is because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring a MDRO and may [sic] residents colonized with a MDRO are asymptomatic or not presently known to be colonized. Enhanced Barrier Precautions expand the use of gown and gloves beyond the anticipated blood and body fluid exposures. They focus on use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. The policy specified EBP was recommended for, 2) A wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO. Indwelling medical devices include central venous catheters, urinary catheters, feeding tubes, tracheostomies/ventilators. The policy further specified, High-contact resident care activities where a gown and gloves should be used include: -Transferring residents from one position to another and -Caring for or using an indwelling medical device.</p> <p>1. An observation on 02/03/2025 at 10:26 AM revealed Resident #103's and Resident #336's room (shared room) had a CDC sign posted on the door that indicated the residents required EBP.</p> <p>The undated CDC signage indicated, ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound Care: any skin openings requiring a dressing.</p> <p>A facility policy titled, Catheter Care, Urinary, dated 12/2024, revealed the section titled Infection Control specified, b. Be sure the catheter tubing and drainage bag are kept off the floor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An Admission Record revealed the facility originally admitted Resident #336 on 01/09/2025 and readmitted Resident #336 on 01/28/2025. According to the Admission Record, Resident #336 had a medical history that included diagnoses of gastrostomy status (presence of a surgically created opening in the stomach) and acute kidney failure.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/16/2025, revealed Resident #336 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #336 utilized a feeding tube while a resident at the facility and received 51 percent (%) or more of their total calories through parenteral or tube feeding.</p> <p>Resident #336's care plan included a focus area, initiated 01/09/2025, that indicated the resident required a feeding tube related to dysphagia (difficulty swallowing). Resident #336's care plan did not address the need for EBP.</p> <p>A Nursing Admission/Readmission Data Collection, dated 01/28/2025, revealed Resident #336 was readmitted to the facility with an indwelling urinary catheter.</p> <p>Resident #336's Order Summary Report contained an order dated 01/27/2025 for a urinary catheter. The Order Summary Report also contained orders dated 02/05/2025 addressing enteral feedings (by way of feeding tube).</p> <p>During a concurrent observation and interview on 02/03/2025 at 10:30 AM, Resident #336 was in a low bed, with the resident's catheter drainage bag and tubing lying on the right side of the bed on the floor. Certified Nursing Assistant (CNA) #14 entered the resident's room wearing a mask and gloves but no gown. CNA #14 pulled the catheter drainage bag and tubing off the floor and emptied the catheter bag. Without washing hands or changing gloves, CNA #14 verified the positioning of Resident #336's catheter by lifting the resident's bedding and touching the resident.</p> <p>During an interview on 02/03/2025 at 10:36 AM, CNA #14 confirmed he/she did not wear a gown when emptying Resident #336's catheter bag and said he/she missed the sign that was posted regarding EBP.</p> <p>An observation on 02/03/2025 at 10:47 AM revealed Resident #336's catheter tubing was on the floor.</p> <p>During an interview on 02/03/2025 at 10:48 AM, CNA #14 confirmed Resident #36's catheter tubing was on the floor and stated catheter tubing was not supposed to be on the floor.</p> <p>An observation on 02/05/2025 at 11:20 AM revealed Registered Nurse (RN) #25 was providing care to Resident #336. RN #25 was not wearing a gown while utilizing the resident's feeding tube.</p> <p>During an interview on 02/05/2024 at 11:50 AM, RN #25 stated she should have worn a gown while providing care to Resident #336 but he/she did not.</p> <p>During an interview on 02/07/2025 at 2:17 PM, Assistant Director of Nursing (ADON) #41 stated that when a resident required EBP, staff should wash their hands before entering and when leaving the resident's room and should wear a gown and gloves when providing resident care. ADON #41 further stated that when performing catheter care, staff should wash their hands before initiating the care and after finishing, prior to touching the resident.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Interim Director of Nursing (IDON) and the Administrator on 02/07/2025 at 3:22 PM, the IDON stated for a resident that required EBP, staff should perform hand hygiene prior to entering the room to provide care and when leaving the room. The IDON further stated that after providing catheter care, staff should wash their hands and change gloves before touching the resident.</p> <p>2. An Admission Record revealed the facility originally admitted Resident #103 on 11/20/2023 and readmitted Resident #103 on 01/09/2025. According to the Admission Record, Resident #103 had a medical history that included diagnoses of dysphagia (difficulty swallowing) and gastrostomy status (presence of a surgically created opening in the stomach).</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/18/2024, revealed Resident #103 had a short-term memory problem but was independent with cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS). The MDS indicated Resident #336 utilized a feeding tube while a resident at the facility and received 51 percent (%) or more of their total calories through parenteral or tube feeding.</p> <p>Resident #103's care plan included a focus area, initiated 07/31/2024, that indicated the resident required EBP due to the presence of a feeding tube.</p> <p>Resident #103's Order Summary Report contained orders dated 01/09/2025 addressing enteral feedings (by way of feeding tube). The Order Summary Report also included an order dated 01/09/2025 for EBP.</p> <p>During an observation on 02/04/2025 at 2:05 PM, the Admissions Coordinator (AC) entered Resident #103's room without performing hand hygiene. Without donning a gown or gloves, the AC assisted Resident #103 by placing the resident's leg back into the bed and repositioning the resident. In addition, the AC assisted the resident by rearranging the resident's pillows and repositioning a pillow under the resident's head. The AC then left the room without performing hand hygiene.</p> <p>During an interview on 02/04/2025 at 2:08 PM, the AC stated he/she should have performed hand hygiene before entering Resident #103's room and should have washed his/her hands after assisting the resident. The AC further stated she guessed he/she should have also worn a gown while assisting Resident #103.</p> <p>During an interview on 02/07/2025 at 2:17 PM, Assistant Director of Nursing (ADON) #41 stated that when a resident required EBP, staff should wash their hands before entering and when leaving the resident's room and should wear a gown and gloves when providing resident care.</p> <p>During an interview with the Interim Director of Nursing (IDON) and the Administrator on 02/07/2025 at 3:22 PM, the IDON stated for a resident that required EBP, staff should perform hand hygiene prior to entering the room to provide care and when leaving the room.</p>		